

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1902

## CERTIFICATE OF DEATH

Reg. Dist. No. 12412 190

## 1. PLACE OF DEATH:

County HOWARD

City or town ELKRIDGE

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

HARRY BIRKETT

4. Sex M

5. Color or race W

6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Florence Birket

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Jan. 30, 1898

8. AGE:

Years 47

Months 11

Days 15

If less than one day hrs. min.

9. Birthplace England

(Town, county, and state)

10. Usual occupation merchant Seaman

11. Industry or business

MOTHER FATHER

12. Name John Birket

13. Birthplace Eng land

MOTHER

14. Maiden name Lorraine

15. Birthplace "

16. Informant Miss Beatrice P. Isaacs

Address 1713 Severn Ave Elbridge Md

17. Burial

Date thereof Dec 19<sup>th</sup> 1945

(month) (day) (year)

Cemetery or crematory

Lorraine

Location

Baltimore Co. Md.

18. Funeral director

William Cook Inc

Address

1217 St. Paul St

19. (Date rec'd by registrar)

12/18/45

Certified by

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State ENGLAND County

City or town LIVERPOOL (If outside city or town limits, write RURAL and give nearest town)

Street No. 20 REGINA Rd.

(If rural, give LOCATION)

2.(a) If veteran, name war

W

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH

12/15 1945 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/15 1945 to 12/15 1945

and that I last saw him alive on 20 date 19

Immediate cause of death

Fracture of skull at base

instant

Due to

Due to

Other conditions

Fracture of pelvis

instant

(Include pregnancy within 3 months of death)

Major findings or operations

none

Date of op.

Autopsy results

none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

accident

Date of 12/15/45

Where did injury occur

Elbridge Howard

(County) (State)

Injured at home, farm, industry, public place (where?)

Baltimore Washington Blvd

Means of injury Struck by auto

Injured at work? no

23. SIGNATURE

GEORGE E. BURGESS MD DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M.D. or other

Address Elizabethtown, Md Date signed 12/15/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 942

## CERTIFICATE OF DEATH

12413  
193

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County Howard Co.City or town Burke, near Florence  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 62 years

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Walter Sullivan Black4. Sex M. 5. Color or race w. 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife atherine Warfield Jones7. Birth date of deceased (mo., day, yr.) Oct. 4 1863 8.(c) If alive, give age 82 years8. AGE: Years 82 Months 2 Days 0 If less than one day hrs. ..... min. ....9. Birthplace Baltimore City Md. (Town, county, and state)10. Usual occupation farmer

11. Industry or business

12. Name Samuel W. Black13. Birthplace Baltimore City Md.14. Maiden name Margaret Gribell15. Birthplace Baltimore Md.16. Informant Mr. J. Hubert BlackAddress Woodbine Carroll Co. Md.17. Burial Burial Date thereof 12/6/45  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory

Location

18. Funeral director C. M. WaltzAddress Westminister Md.19. Date rec'd by registrar Dec. 5, 1945 A. J. H. Hedrick  
(Date rec'd by registrar) (Registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Florence near Woodbine  
(If outside city or town limits, write RURAL and give nearest town)Street No. Rural near Florence & Woodbine  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 4 1945 at 9:30 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept Oct 11, 1945, to Dec 4, 1945and that I last saw him alive on Dec 3 1945

Immediate cause of death

Coronary Thrombosis DURATION 1 daDue to Coronary arterio sclerosis 6 yrsDue to General arterio-sclerosis ? yrs

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations none

Date of op.

Autopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

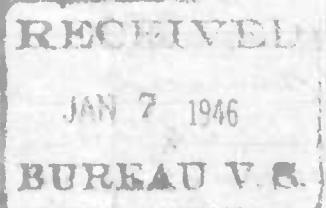
Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

## 23. SIGNATURE

J. Stanley Grubell M. D. number 12/6/45  
Address Metairie, La. Date signed 12/6/45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 950

## CERTIFICATE OF DEATH

12414

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County Howard  
City or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Alexander Brown

4. Sex

5. Color or race

B.(a) Single, married, widowed, or divorced

m c Widower

6. (b) Name of husband or wife

Stacey Brown

7. Birth date of deceased (mo., day, yr.)

6. (c) If alive, give age years

Jan. 14, 1870

8. AGE:

Years

Months

Days

If less than one day

75

10

22

hrs. min.

9. Birthplace

Maryland  
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

William Brown

FATHER

12. Name

13. Birthplace

md

MOTHER

14. Maiden name

Louisa Madden

15. Birthplace

md

16. Informant

Mrs. Edward Wynn

Address

Elkridge, Md.

17. (Burial, cremation, or removal. Which?)

Date thereof 12-9-45

(month) (day) (year)

Cemetery or crematory

St. Paul's

Location

Delta Md

18. Funeral director

F.C. Dugan & Son

Address

Elkridge City Md

19. (Date rec'd by registrar)

Dec. 9, 1945

John B. Vaughan

John B. Vaughan  
Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County HowardCity or town Elkridge  
(If outside city or town limits, write RURAL and give nearest town)Street No. Route 4  
(If rural, give LOCATION)

2. (a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 6, 1945 at 1 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec. 5, 1945 to Dec. 6, 1945and that I last saw him alive on Dec. 6, 1945

Immediate cause of death

Accident  
Gasoline  
End Paraldehyde Decolor

DURATION

2 days  
2 yrs.

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

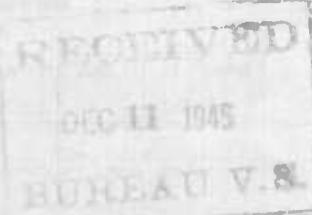
Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURES

John B. Vaughan M. D. or otherAddress Elkridge Md. Date signed 12-7-45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

12415

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County.....

Howard  
Main Street Ellicott City

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Ellanore Brown

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female Colored Single

## 6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

6. (c) If alive, give age..... years

Jan. 17, 1867

8. AGE:

Years

Months

Days

It less than one day

78

10

23

hrs.

min.

9. Birthplace

Howard Co. Md.

(Town, county, and state)

10. Usual occupation

Domestic

## 11. Industry or business

MOTHER FATHER

12. Name

John Brown

Howard Co.

13. Birthplace

Howard Co.

Md.

14. Maiden name

Martha Suga

15. Birthplace

Howard Co. Md.

16. Informant

Mrs. Alice Stevenson

Address

Ellicott City Md.

Burial

(Burial, cremation, or removal, Which?)

Date thereof.....

(month) (day) (year)

Cemetery or crematory

Western Star Cem.

Location

Baltimore Co. Md.

18. Funeral director

Easton Sons

Address

Ellicott City, Md.

19. Dec 13

1945

(Date rec'd by registrar)

John B. Langham

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Howard

City or town..... Ellicott City (If outside city or town limits, write RURAL and give nearest town)

Street No..... Main Street (If rural, give LOCATION)

2.(a) If veteran, name war..... None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... Dec. 10, 1945, at 10:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan. 23, 1939, to Dec. 10, 1945,

and that I last saw her alive on Dec. 10, 1945.

## Immediate cause of death.....

Hypertensive Cardio-  
Vascular Disease

DURATION

6 year.

Due to.....

Due to.....

Other conditions..... Arthritis

2 yr.

(Include pregnancy within 8 months of death)

## Major findings of operations..... none

Date of op.

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

George E. Brugtoland M.D. or other

Address..... Ellicott City, Md. Date signed..... Dec 11, 1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 930

## CERTIFICATE OF DEATH

12416  
Reg. Dist. No. 190

## 1. PLACE OF DEATH:

County HowardCity or town Elkridge

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 yearsHospital, institution, or street address where death occurred: Wash Blvd.

How long in hospital or institution? \_\_\_\_\_

## 3. (a) FULL NAME

Susie Sarah Creamer4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife William F. Creamer7. Birth date of deceased (mo., day, yr.) Oct 11 18548. AGE: Years 91 Months 1 Days 6 If less than one day hrs. 00 min. 009. Birthplace Loudon Co. Va.  
(Town, county, and state)10. Usual occupation Domestic11. Industry or business Retired12. Name 7 Perry13. Birthplace Virginia14. Maiden name Markham

15. Birthplace \_\_\_\_\_

16. Informant Mrs. Wm. F. CreamerAddress Elkridge 22 Md17. Removal Removal Date thereof 12.17.45

(Burial, cremation, or removal. Which?)

Cemetery or crematory Salem Methodist CemeteryLocation Hillsboro-Loudon Co. VA18. Funeral director Eason SonsAddress Elkridge City - Md19. Date rec'd by registrar Dec 17 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MdCounty HowardCity or town Elkridge

(If outside city or town limits, write RURAL and give nearest town)

Street No. Wash Blvd.

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (b) Social Security Number \_\_\_\_\_

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 17 1945 \$1 8A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dec 15 1945 to Dec 17 1945and that I last saw her alive on Dec 16 1945Immediate cause of death Chronic bronchitisDURATION 6 moDue to Arthritis 10 yrsDue to Arteriosclerosis 60 yrsOther conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

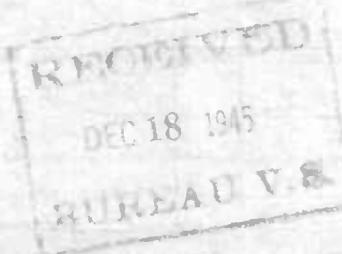
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —Where did injury occur? — (City or town) — (County) — (State)Injured at home, farm, industry, public place (where?) —Means of injury — Injured at work? —23. SIGNATURE B. Brun Lang

M. D. or other

Address Elkridge MdDate signed 12/17/45



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## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

## CERTIFICATE OF DEATH

12417

195

Reg. Dist. No.

1. PLACE OF DEATH: Howard  
County Gulfport

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Jessup R. F. D.

How long in hospital or institution?

3. (a) FULL NAME Hugh Francis Cullen

4. Sex M. 5. Color or race Irish 6. (a) Single, married, widowed, or divorced Married

6. (b) Name of husband or wife Eleanor Cullen

7. Birth date of deceased (mo., day, yr.) Nov 19 1885 6. (c) If alive, give age ..... years

8. AGE: Years 07 Months 8 Days 14 If less than one day

hrs. 0 min. 0

9. Birthplace Yorkshire Eng. (Town, county, and state)

10. Usual occupation Miner

11. Industry or business John Cullens

FATHER 12. Name John Cullens

MOTHER 13. Birthplace England

14. Maiden name Matilda McPartland

15. Birthplace England

16. Informant Mr. Edward Cullen

Address 2000 P. St. N.W. Wash. D.C.

17. (Burial, cremation, or removal. Which?) Burial Date thereof Dec 6, 1945 (month) (day) (year)

Cemetery or crematory Woodlawn Cemetery

Location Bladensburg Rd. Md.

18. Funeral director Frank Shiley

Address 23rd & E. St. Wash. D.C.

19. (Date rec'd by registrar) 12/16/45 Frank Shiley

Registrar Frank Shiley

(Date rec'd by registrar) 12/16/45

Frank Shiley

Registrar Frank Shiley

(Date signed) 12/3/45

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)

State Md. County Howard

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

Street No. Jessup R. F. D.

(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH 12-3-45 at 10 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Die 3 1945 to Dec 3 1945, te. 10 AM

and that I last saw him alive on 10 AM 1945

Immediate cause of death Coronary Thrombosis

Due to Myocarditis

Due to Obesity

Other conditions Obesity

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op. \_\_\_\_\_

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) .....

Means of injury ..... Injured at work? .....

23. SIGNATURE W. Warren M.D.

M. D. or other Paired

Date signed 12/3/45

RECEIVED

DEC 10 1945

BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46B

## CERTIFICATE OF DEATH

12418

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County Newark  
City or town Elliott City  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Anna Louise Dromfield4. Sex F 5. Color or race W 6.(a) Single, married, widowed, or divorced married8. (b) Name of husband or wife Bessie Louise Dromfield7. Birth date of decedent (mo., day, yr.) Sept. 15, 1886 8. (c) If alive, give age years8. AGE: Year 59 Months 2 Day 22 If less than one day hrs. min.9. Birthplace Baltimore, Md. (Town, county, and state)10. Usual occupation at home

## 11. Industry or business

FATHER 12. Name Wes W. ThompsonMOTHER FATHER 13. Birthplace Eng landMOTHER 14. Maiden name Mary MarshallMOTHER 15. Birthplace Eng land16. Informant Anna Louise DromfieldAddress Elliott City, Md.17. Burial Date thereof Dec. 11, 1945 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory St. John'sLocation Elliott City, Md.18. Funeral director J.C. Nagle, undertakerAddress Elliott City, Md.

19. Dec. 9, 1945 (Date rec'd by registrar)

Registrar  
John B. Loughran  
P.S. E. E.

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County NewarkCity or town Elliott City (If outside city or town limits, write RURAL and give nearest town)Street No. St. John's Lane (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1945 at 10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 16, 1945 to Dec. 7, 1945 and that I last saw her alive on Dec. 7, 1945

Immediate cause of death

Carcinoma of Stomach DURATION 1 yr.

Due to

Due to

Other conditions

none (Include pregnancy within 3 months of death)Major findings or operations Carcinoma of Stomach Date of op. 6-27-45

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

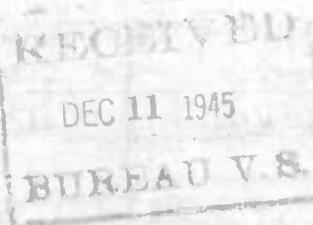
Means of injury Injured at work?

## 23. SIGNATURE

Geo E. Burdett M.D. M. D. or otherAddress Elliott City, Md. Date signed Dec. 8, 1945

RECEIVED BY TELETYPE STATION WASHINGTON

TELETYPE TRANSMITTER



**PLEASE WRITE PLAINLY, WITH UNFADING INK.** Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2D

12419

Reg. Dist. No. 191

## CERTIFICATE OF DEATH

## 1. PLACE OF DEATH:

County HowardCity or town Ellicott City Rural

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Elizabeth Hammond

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

F

C

Widow

6.(b) Name of husband or wife Richard Hammond

7. Birth date of deceased (mo., day, yr.)

1875

8. AGE:

Years

Months

Days

If less than one day

70

hrs.

min.

9. Birthplace Howard County Md

(Town, county, and state)

10. Usual occupation At home

## 11. Industry or business

12. Name Unknown

13. Birthplace "

14. Maiden name "

15. Birthplace "

16. Informant Joseph JonesAddress Ellicott City, Md.17. Burial Burial

(Burial, cremation, or removal. Which?)

Date thereof 12-15-45

(month) (day) (year)

Cemetery or crematory St. LouisLocation Clarksville18. Funeral director F.C. HiginbothamAddress Ellicott City, Md.19. 12/15

1945

John B. Loughran

Registrar

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MarylandCounty HowardCity or town Ellicott City Rural

(If outside city or town limits, write RURAL and give nearest town)

Street No. Carroll's Manor

(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH December 13 1945 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 - 14 1945 to 12/13 1945and that I last saw her alive on 12/13 1945

Immediate cause of death

Hypertensive Cardiovascular Disease

DURATION

1 year

Due to

Due to

Other conditions Hypoglycemia - stroke 4 months

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE George E. Baugler M.D.

M. D. or other

Address Ellicott City, Md. Date signed 12/14/45

RECEIVED

DEC 20 1945

BUREAU V.S.

3

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 13-20

## CERTIFICATE OF DEATH

124211

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County

Howard  
Ellicott City, Md.

(If outside city or town limits, write MURAL and give nearest town)

How long in above place of death? 82 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

Emma Virginia Harding

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widower

6. (b) Name of husband or wife Wm. H. Harding

7. Birth date of deceased (mo., day, yr.) Feb. 1, 1863 6. (c) If alive, give age years

8. AGE: Years Months Days If less than one day

82 10 6 hrs. min.

9. Birthplace Ellicott City, Howard County

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name James Oliver Jones

13. Birthplace Unknown

14. Maiden name Sarah Connor

15. Birthplace Unknown

16. Informant Alpheus Harding

Address Clarksville Pike

17. Burial Date thereof Dec. 10, 1945

(Burial, cremation, or removal: Which?) (month) (day) (year)

Cemetery or crematory St. Johns Cem.

Location Ellicott City, Md.

18. Funeral director Easton Sons

Address Ellicott City, Md.

19. Date rec'd by registrar Dec. 10, 1945 John B. Loughran  
(Date rec'd by registrar) Au. B. E. 2. Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Howard

City or town Ellicott City, Md.

(If outside city or town limits, write MURAL and give nearest town)

Street No. Clarksville Pike

(If rural, give LOCATION)

2.(a) If veteran, name war None

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec. 7, 1945 at 2:10 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Jan 1945 to Dec. 7 1945

and that I last saw her alive on Dec. 7 1945

Immediate cause of death

General Lethargy

DURATION

4 days

Due to Osteoarthritis Hypertension  
Cardiovascular disease

Due to Atherosclerosis

?

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of .....

Where did injury occur? ..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

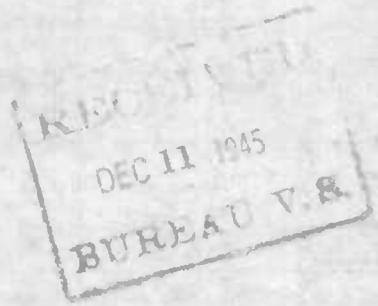
Means of injury

Injured at work?

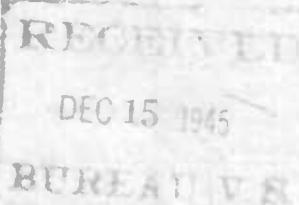
23. SIGNATURE

M. D. or other

Address Ellicott City, Md. Date signed Dec. 9, 1945







PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 2d

12422

## CERTIFICATE OF DEATH

Reg. Dist. No. 190

## I. PLACE OF DEATH:

County HowardCity or town Elderside  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 42 yrsHospital, Institution, or street address where death occurred: Landing RdHow long in hospital or institution? 

## 3. (a) FULL NAME

James William Elshart4. Sex Male 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed8. (b) Name of husband or wife Catherine AgnesElshart 1945 It alive, give age years7. Birth date of deceased (mo., day, yr.) Apr 8 - 18558. AGE: Years 90 Months 8 Days 2 If less than one day  hrs.  min. 9. Birthplace Elderside, Howard Co. Md.  
(Town, county, and state)10. Usual occupation Harrower11. Industry or business "12. Name William Elshart13. Birthplace Md.14. Maiden name Elizabeth Mullaway15. Birthplace Howard Co. Md.16. Informant Clarence W. ElshartAddress Elderside, 27 m17. Burial Burial Date thereof Dec. 13, 1945  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or columbarium St. John's CemeteryLocation Ellicott City, Md.18. Funeral director Castor SonsAddress 608 Frederick Ave. Catons, Md.19. Date rec'd by registrar Dec. 12 1945 Miss C. Bird Well

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md.County HowardCity or town Elderside  
(If outside city or town limits, write RURAL and give nearest town)Street No. Landing Rd  
(If rural, give LOCATION)2.(a) If veteran, name war none3. (b) Social Security Number none

## MEDICAL CERTIFICATION

20. DATE OF DEATH Dec 10 1945 at 10:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 1945 to Dec 10 1945and that I last saw h... f... alive on Dec 10 1945

Immediate cause of death

Chronic Angina Cardia& Decompensation 3 m

Due to

General arteriosclerosis

Due to

Tendinitis

Other conditions

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op. 

Autopsy results

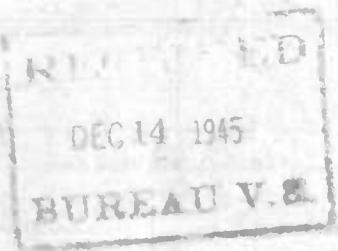
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide  Date of Where did injury occur?  (City or town)  (County)  (State)Injured at home, farm, industry, public place (where?) Means of injury  Injured at work? 

## 23. SIGNATURE

M. D. or other J. B. BlundellAddress 1609 Main St Elderside Date signed Dec 10 1945





✓ PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for addition of place of death is shown on

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

162-E

12423  
Reg. Dist. No. 193

FILM No. 100 JAN 11 1946

## CERTIFICATE OF DEATH

### 1. PLACE OF DEATH:

Howard County  
Montgomery Co. MD

Near Long Corner at Shafersville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

### 3. (a) FULL NAME

Charles E. Loston

4. Sex      5. Color or race      6. (a) Single, married, widowed, or divorced

Male      W      Widower

6. (b) Name of husband or wife      Martha Agnes Ward

7. Birth date of deceased (mo., day, yr.)      May 1, 1858      6. (c) If alive, give age      years

8. AGE:      Years      Months      Days      If less than one day      hrs.      min.

9. Birthplace      Montgomery Co. MD  
(Town, county, and state)

10. Usual occupation:

11. Industry or business

12. Name      Emery Loston

13. Birthplace      Maryland

14. Maiden name      Sarah Ward

15. Birthplace      Not

16. Informant      Mrs. Emery Loston Budette

Address      Schafferville MD

17. Burial      Burial      Date thereof      Dec 27/1945

(Burial, cremation, or removal. Which?)      (month) (day) (year)

Cemetery or columbarium      Jennings Chapel

Location      Howard Co. MD

18. Funeral director      Roy W. Barber

Address      Shafferville MD

19. (Date rec'd by registrar)      1945      E. Paul Dyer

Registrar

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State      Maryland      County      Montgomery MD

City or town      (If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war

### 3. (b) Social Security Number

### MEDICAL CERTIFICATION

20. DATE OF DEATH      Dec 26 1945 2:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Mar 4 1950 to Dec 26 1945

and that I last saw him alive on Dec 20 1945

Immediate cause of death

General debility due to old age  
Due to heart just gave out  
from general debility

DURATION

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?      (City or town)      (County)      (State)

Injured at home, farm, industry, public place (where?)

Means of injury

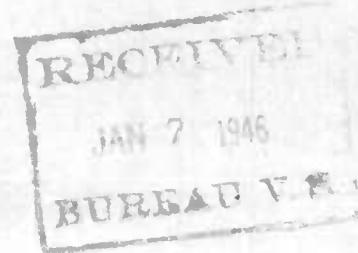
Injured at work?

23. SIGNATURE

C. M. van Poel

M. D. — other

Address      Dixie Drd      Date signed 12/26/45



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

12424

## CERTIFICATE OF DEATH

Reg. Dist. No. 191

## 1. PLACE OF DEATH:

County

City or town

Howard  
Eliotak

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 74 yrs

Hospital, Institution, or street address where death occurred:

How long in hospital or institution?

## 3. (a) FULL NAME

4. Sex

5. Color or race

6. (a) Single, married, widowed, or divorced

Female White Single

6. (b) Name of husband or wife

None

7. Birth date of deceased (mo., day, yr.)

B. (c) If alive, give age years

May 22, 1871

8. AGE:

Years

Months

Days

If less than one day

hrs. min.

74

7

1

9. Birthplace

Eliotak Howard Co. Md.

(Town, county, and state)

10. Usual occupation

Household duties

11. Industry or business

Own home

FATHER



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1102

## CERTIFICATE OF DEATH

12425

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

Howard County

Savage, Balto. Wash. Blvd.

(If outside city or town limits, write RURAL and give nearest town)

45 Min.

How long in above place of death?

Hospital, Institution, or street address where death occurred:

Rt. # 1 Savage, Md.

None

## 3. (a) FULL NAME

William F. Mathews

## 3. (b) Social Security Number

## 4. Sex      5. Color or race      6.(a) Single, married, widowed, or divorced

Male      W      No

6.(b) Name of husband or wife..... Unknown

7. Birth date of deceased (mo. day. yr.) 20 February 1924

8. AGE: Years      Months      Days      If less than one day  
21      10      4      hrs.      min.9. Birthplace..... Unknown  
(Town, county, and state)

10. Usual occupation..... Soldier

11. Industry or business..... U. S. Army

12. Name..... Unknown

13. Birthplace..... Unknown

14. Maiden name..... Unknown

15. Birthplace..... Unknown

16. Informant.....

Address

17. Burial, cremation, or removal. Which? Removal Date thereof 12/24/45  
(Burling, cremation, or removal. Which?)

(month) (day) (year)

Cemetery or crematory..... Syona Funeral Home

Location..... 1325 1/2 N. St. N.W. Washington, D.C.

18. Funeral director..... Howard H. Blight Jr.

Address..... 4914 Belair Road

19. Date rec'd by registrar..... 24 December 1945

(Date rec'd by registrar)

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... Maryland County..... Mondy.

City or town..... Kensington, Md.

(If outside city or town limits, write RURAL and give nearest town)

Street No..... 57 Kensington, Parkway

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## MEDICAL CERTIFICATION

20. DATE OF DEATH..... 12/24 1945 at 1 15 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

12/24 1945 to 12/24 1945

and that I last saw h. m. alive on no date 1945

Immediate cause of death..... broken neck

DURATION

instant

Due to traumatic rupture of right ventricle  
of heart. cause

Due to.....

Other conditions..... 3 fractured ribs on rt. instant

(Include pregnancy within 8 months of death)

Major findings of operations..... none

Date of op. ....

Autopsy results..... none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, tell in the following:

Accident, suicide, or homicide..... accident Date of 12/23/45

Where did injury occur? New Savage Howard Md.  
(City or town) (County) (State)

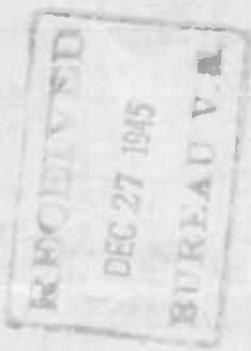
Injured at home, farm, Industry, public place (where?) Highway Route #1

Means of injury Auto Collision Injured at work? No

23. SIGNATURE

DEPUTY MEDICAL EXAMINER OF HOWARD COUNTY M.D. or other

Address..... Elliott City, Md. Date signed 12/24/45





PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians; please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

12420

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

County HOWARDCity or town NEAR ELLICOTT CITY

(If outside city or town limits, write RURAL and give nearest town)

TWO DAYS

How long in above place of death?

Hospital, institution, or street address where death occurred:

PINEL CLINIC - HOWARD COUNTYHow long in hospital or institution? TWO DAYS

## 3. (a) FULL NAME

FREDERICK HARDING SHEPHERD

4. Sex

5. Color or race

6.(a) Single, married, widowed, or divorced

MALEWHITEDIVORCED

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo. day. yr.)

DECEMBER 17 1892

6.(c) If alive, give age..... years

8. AGE:

Years	Months	Days	If less than one day
<u>52</u>	<u>52</u>	<u>11</u>	<u>17</u>
			hrs. ..... min.

9. Birthplace

Mc MINNVILLE TENNESSEE

(Town, county, and state)

10. Usual occupation

PRINTER

11. Industry or business

12. Name THOMAS SHEPHERD13. Birthplace ROANOKE - VIRGINIA14. Maiden name LURAH WADE15. Birthplace TENNESSEE

16. Informant

Address MARINE HOSPITAL BALTO WYMAN PK

17. Burial

(Burial, cremation, or removal Which?)

Date thereof Dec. 8 45

(month) (day) (year)

Cemetery or crematory Anglican BatalianLocation Anglican Par18. Funeral director Oscar Farrell funeral DirAddress 4644 York. A.D.

19. (Date record by registrar)

19

65

Budde

Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MARYLANDCounty BALTIMORE CITYCity or town BALTIMORE CITY

(If outside city or town limits, write RURAL and give nearest town)

Street No. 5 W FRANKLIN STREET

(If rural, give LOCATION)

2.(a) If veteran, name war WORLD WAR 1917 / 1918

## 3. (b) Social Security Number

## MEDICAL CERTIFICATION

20. DATE OF DEATH DECEMBER 4<sup>th</sup> 1945

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

DECEMBER 3<sup>rd</sup> 1945 to DECEMBER 4<sup>th</sup> 1945and that I last saw him alive on DECEMBER 4<sup>th</sup> 1945

Immediate cause of death

CEREBRAL HEMORRHAGE

DURATION

5 HOURS

Due to

Due to

Other conditions CHRONIC ALCOHOLISM

(Include pregnancy within 8 months of death)

Major findings or operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Herman Prager M.D.

M. D. or other

Address ELLICOTT CITY M.D. Date signed 12/4/1945



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 932

## CERTIFICATE OF DEATH

12428  
Reg. Dist. No. 771192

## 1. PLACE OF DEATH:

County.....

City or town.....  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?.....

Hospital, institution, or street address where death occurred:.....

How long in hospital or institution?.....

## 3. (a) FULL NAME

Blanche Wherett

4. Sex

F

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife.....

7. Birth date of deceased (mo., day, yr.)

8. (c) If alive, give age..... years

June 10, 1872

8. AGE: Years

73

5

26

Days

If less than one day

hrs.

min.

9. Birthplace.....

(Town, county, and state)

10. Usual occupation.....

Retired

11. Industry or business

FATHER

12. Name.....

13. Birthplace.....

14. Maiden name.....

15. Birthplace.....

16. Informant.....

Address.....

17. Cremation?.....

(Burial, cremation, or removal. Which?)

Date thereof (Mo. Day Year)

(month) (day) (year)

Cemetery or crematory.....

Location.....

18. Funeral director.....

Address.....

19. Date rec'd by Registrar.....

(Date rec'd by Registrar)

John B. Daugherty.....

John B. Daugherty, Registrar

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State.....

Maryland County Howard

City or town.....

Marriottsville (If outside city or town limits, write RURAL and give nearest town)

Street No.....

(If rural, give LOCATION)

2.(a) If veteran, name war.....

## 3. (b) Social Security Number

None

## MEDICAL CERTIFICATION

20. DATE OF DEATH.....

Dec. 6 1941 at 6 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from

Oct. 1 1941 to Dec. 6 1941

and that I last saw her alive on Dec. 5 1941

Immediate cause of death.....

Hypertension heart disease

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.....

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of Injury.....

Injured at work?

23. SIGNATURE.....

John P. Tolman M.D. or other

Address..... Date signed.....

